COVERING THE UNINSURED 10-11

RETHINKING HEALTH INSURANCE 4

SARS LESSONS FOR U.S. 9

HEALTH CARE NEWS

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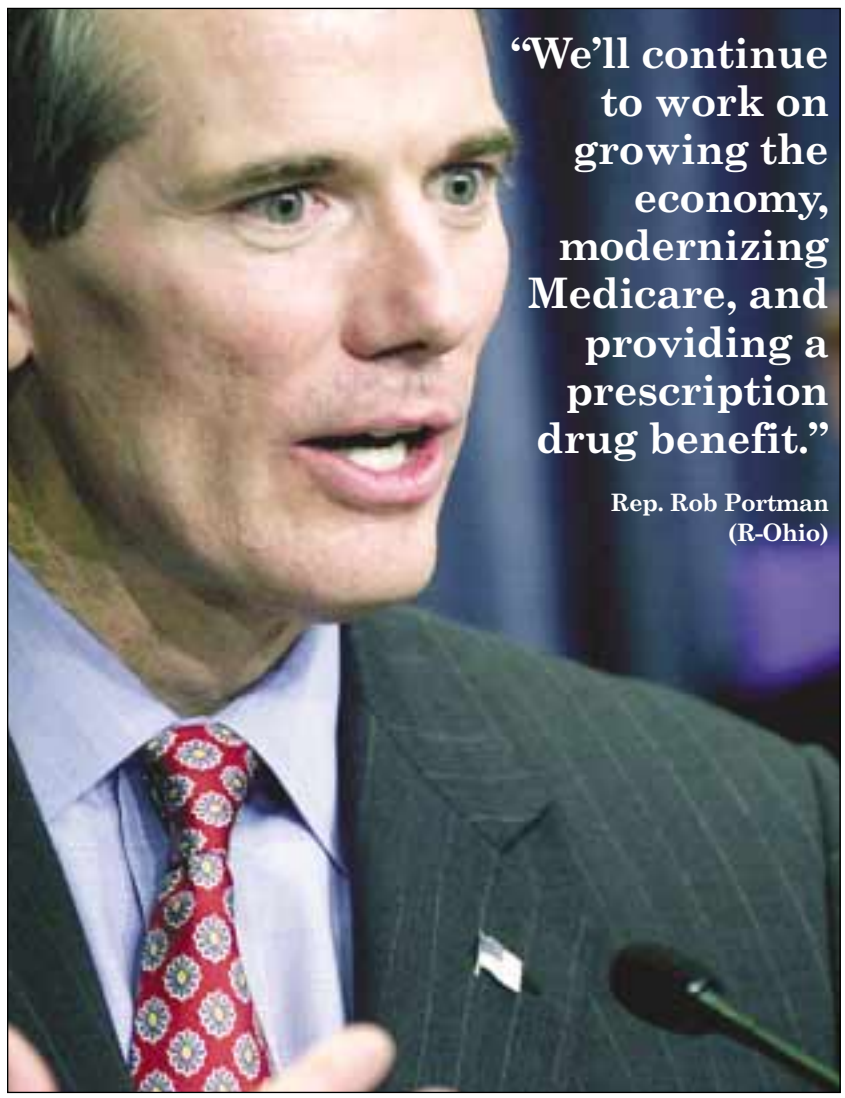
U.S. Malpractice Reform Takes Hit



KRT

Conrad F. Meier

While the war in Iraq has distracted Congress from medical malpractice reform, it appears legislators remain focused on Medicare reform and the creation of a workable prescription drug benefit program for seniors.

A spokesperson for the House Ways and Means Committee said despite the war Congress will continue to work on domestic priorities—especially "taxes and Medicare." Rep. Rob Portman (R-Ohio) said the GOP would "absolutely" carry on with its domestic agenda, adding, "We'll continue to work on growing the economy, modernizing Medicare, and providing a prescription drug benefit."

At the same time, CongressDaily/AM reports malpractice reform legislation has been "bumped ... off the schedule in the near term." That is cause for concern for the American Medical Association, whose president-elect, Dr. Donald Palmisano, says lawmakers must pass malpractice reform for "the good of patients and doctors alike."

The AMA supports legislation (HR 5) passed by the House in March capping punitive damages at $250,000 or twice the amount of economic damages, whichever is higher. In addition, the bill would allow state governments

MALPRACTICE continued on page 16

Smallpox Compensation Law Stalls

Conrad F. Meier

Despite a recent floor defeat, House Republicans say they have not given up on a bill to create a federal compensation program for those harmed by the smallpox vaccine.

"We're looking at other options," House Majority Leader Tom DeLay (R) told reporters at a press briefing.

TOM DeLAY

Among those options is attaching the proposal to an emergency spending bill for the war effort, now moving through both the House and Senate. The smallpox compensation plan, riding as an amendment, would provide a lump-sum benefit of $262,100 to those who are permanently disabled by the vaccine or to the survivors of vaccine victims who die, and up to $75,000 in lost wages annually.

DeLay blamed the Bush administration for the bill's defeat. House Republican leaders introduced the measure under a fast-track procedure known as "suspension," which bars amendments. But measures introduced that way also require a two-thirds majority to pass. The bill failed to receive even a simple major-

SMALLPOX continued on page 6

FDA Cracks Down on Drug Reimportation

Grace-Marie Turner

Seniors who have been buying cheap drugs over the Internet from Canada soon are likely to be searching for new suppliers.

The U.S. Food and Drug Administration (FDA) issued a letter threatening criminal and civil action against any companies that aid the illegal practice. That would target insurance companies like UnitedHealth Group that pay for drugs purchased abroad. The FDA is quick to point out enforcement priorities will not be against consumers.

It's the Law

In cracking down on imports, the FDA is only doing its job. Under U.S. law, it is illegal to import prescription drugs from other countries, including through Internet sites, without explicit FDA approval. The law was passed in 1988 to protect U.S. citizens from fake and contaminated imported medicines.

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Choice in Europe

Johan Hjertqvist

European governments have struggled to combine their traditional ethos of equity in health care with the demands of a more sophisticated, consumer-driven society.

Few expected their inspiration for reform might come from Sweden. Yet this country, known for its deeply rooted belief in the welfare state, has changed as it has come under pressure from both patients and health service workers.

Swiss Model

The shift from a health care system characterised by public service monopoly,

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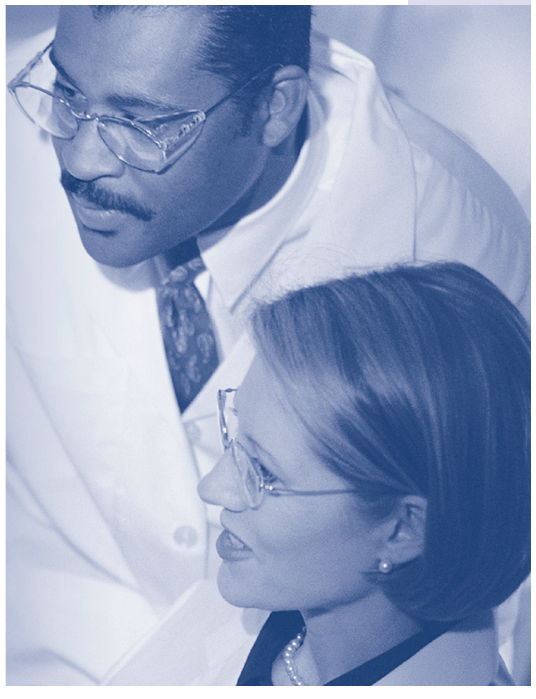

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Market-based Health Care Reform Can Spur the Economy

Chris Middleton

The federal government released data in January showing the United States spent $1.4 trillion—$5,035 per capita—on health care in 2001. This year, spending could increase to nearly $1.7 trillion. Yet all around us, the health care system is falling into chaos.

Headlines Tell the Story

Physicians staged a walkout in West Virginia over skyrocketing malpractice insurance premiums. Doctors are refusing to see new Medicare patients, and some are opting out of the program altogether. And the number of uninsured Americans continues to rise, prompted in part by employers dropping coverage and states cutting back on their Medicaid programs.

At the same time, the Bush administration and Congress are looking for ways to stoke the fires of a lukewarm economy.

These problems are not unrelated. Done correctly, health care reform can simultaneously promote economic growth and improve our health care system. Consider the HMO revolution of a decade ago.

HMOs didn't provide the level of care they promised, but they did restrain costs, which gave an important boost to the economy during the 1990s. With managed care now on the decline, the solution lies in finding new ways to eliminate waste and redundancy from the financing of health benefits and promote the efficient use of health care dollars among individuals and their families.

Reform Begins with Seniors

Given their influence, large and growing, over the country's health care system and its cost, senior citizens are the audience that will benefit first from reform.

Currently, many seniors must obtain a second health insurance plan if they want coverage for prescription drugs and other benefits not covered by Medicare. Some are fortunate enough to have supplemental coverage from a former employer, and this has been an important source of drug coverage for many seniors. Prescription drugs account for roughly half of employers' health expenses for Medicare retirees.

Seniors without this option must buy their own "Medigap" policy if they want supplemental coverage. But Medigap plans cost thousands of dollars and provide little or no coverage for prescription drugs.

Thus, a key aim of Medicare reform should be enabling beneficiaries to purchase a single private health insurance plan for all their needs. If reform can achieve that goal, employer-sponsored Medicare supplement plans and Medigap plans would become obsolete.

For employers, the elimination of Medicare supplement plans would free up resources for hiring and capital expenditures. For seniors with Medigap, the ability to purchase a single Medicare plan would be like a tax cut. Some of the thousands of dollars previously spent on Medigap premiums could be put toward the cost of a single comprehensive plan, with the remaining funds available for other savings and consumption.

"[A] key aim of Medicare reform should be enabling beneficiaries to purchase a single private health insurance plan for all their needs."

Expand MSAs

Another long-overdue reform is the expansion of medical savings accounts (MSAs). When the MSA pilot program was first discussed in the mid-1990s, opponents proclaimed MSAs would destroy the U.S. health care system. Not only has the system survived, but MSAs have encouraged a very healthy trend away from managed care and toward consumer-driven health plans. Nevertheless, tax-free Archer MSAs remain a limited demonstration project set to expire on December 31, 2003.

Before that deadline is reached, Congress should make MSAs available to all citizens on a permanent basis. MSAs empower patients to become selective, cost-conscious consumers in the health care marketplace. The cost-conscious shopping encouraged by MSAs will slow the growth of health care spending, making funds available for other purposes, benefitting the economy by helping to keep interest rates low and investment rates high.

Reforms for the Uninsured

Tax credits for health insurance provide the most effective way to help those who have been left out of the employment-based health insurance system. The uninsured are mostly low-income employees and those working for small businesses. Because tax credits are portable, they promote economic growth by putting an end to "job lock" and encouraging entrepreneurship. With tax credits available for their own purchase of health insurance, workers who wish to start their own business or join a small start-up firm will no longer be dissuaded from doing so by the threat of losing coverage.

Key Reform for Providers

Tort reform for medical malpractice insurance is essential to bringing down the cost of doing business for physicians. California's MICRA law provides a model for the nation. It caps non-economic damage awards for pain and suffering at $250,000, and places limits on attorney's fees.

Since MICRA's passage, malpractice insurance premiums in California have gone from among the highest in the nation to among the lowest. This has helped keep health insurance premiums in California below the national average.

Dangerous Waters Ahead

While the benefits of real health care reform would be many, the pursuit of reform is not without risk. Lawmakers must guard against proposals that rely on massive new government spending. Such spending diverts funds from the private sector that would otherwise be used towards savings or consumption—the real engines of economic growth. Sound health care reform need not be costly, and proposals that are costly almost invariably reflect bad health care policy.

There is no conflict between good health care policy and sound economic policy. Federal lawmakers should recognize this and act accordingly.

Chris Middleton is the senior health and tax policy analyst for the Center For Entrepreneurship at the Pacific Research Institute in San Francisco. His email address is **cmiddleton@pacificresearch.org.**

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Rethinking Health Insurance

Milton Friedman

Managing Editor's Note:
Milton Friedman, recipient of the 1976 Nobel Memorial Prize for economic science, wrote this almost two years ago. His sage observations then are even more meaningful today.

Since the end of World War II, the provision of medical care in the United States and other advanced countries has displayed three major features: first, rapid advance in the science of medicine; second, large increases in spending, both in terms of inflation-adjusted dollars per person and the fraction of national income spent on medical care; and third, rising dissatisfaction with the delivery of medical care, on the part of both consumers of medical care, and physicians and other suppliers of medical care.

A key difference between medical care and other technological revolutions is the role of government. In other technological revolutions, the initiative, financing, production, and distribution were primarily private, though government sometimes played a supporting or regulatory role.

In medical care, government has come to play a leading role in financing, producing, and delivering medical service. Direct government spending on health care now exceeds 75 percent of total health spending for 15 Organization for Economic Cooperation and Development (OECD) countries. For the U.S., the figure is 46 percent.

Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party—an insurance company or employer or governmental body.

The second is that nobody spends somebody else's money as wisely or as frugally as he spends his own. These statements apply equally to other OECD countries.

"Throughout the OECD countries, third-party payment has required the bureaucratization of medical care and, in the process, has changed the character of the relation between physicians or other caregivers and patients."

Why are most medical payments made by third parties? The answer for the United States begins with the fact that medical care expenditures are exempt from federal income tax if, and only if, medical care is provided by the employer. If an employee pays directly for medical care, the expenditure comes out of the employee's income after income tax.

That strong incentive explains why most consumers get their medical care through their own employer, or their spouse's or parents' employer. The tax exemption of employer-provided medical care in the U.S. has two different effects, both of which raise health care costs.

First, it leads American workers to rely on their employer, rather than themselves, to make arrangements for medical care. Second, it leads employees to take a larger fraction of their total remuneration in the form of medical care than they would if spending on medical care had the same tax status as other expenditures.

Employer financing of medical care in the U.S. has caused the term "insurance" to acquire a rather different meaning in medicine than in most other contexts. We generally rely on insurance to protect us against events that are highly unlikely to occur but involve large losses if they do occur—major catastrophes, not minor regularly recurring expenses. We insure our houses against loss from fire, not against the cost of having to mow the lawn. We insure our cars against liability to others or major damage, not against having to pay for gasoline. Yet in medicine, it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions.

Moreover, the states and the federal government have increasingly specified the coverage of insurance for medical care to a detail not common in other areas. The effect has been to raise the cost of insurance and to limit the options open to individuals. If the tax exemption for employer-provided medical care had never been enacted, the insurance market for medical care would probably have developed as other insurance markets have—as a way of providing for catastrophic, out-of-the-ordinary costs, not for routine expenditures.

Throughout the OECD countries, third-party payment has required the bureaucratization of medical care and, in the process, has changed the character of the relation between physicians or other caregivers and patients. A medical transaction is not simply between a caregiver and a patient; it has to be approved as "covered" by a private- or public-sector bureaucrat and the appropriate payment authorized.

An inescapable result is that the interest of the patient is often in direct conflict with the interests of the caregiver's ultimate employer—whether the latter is a government or a corporation.

Milton Friedman, recipient of the 1976 Nobel Memorial Prize for economic science, has been a senior research fellow at the Hoover Institution since 1977.
This article was excerpted from the Winter 2001 issue of The Public Interest **(http://www.thepublicinterest.com).**

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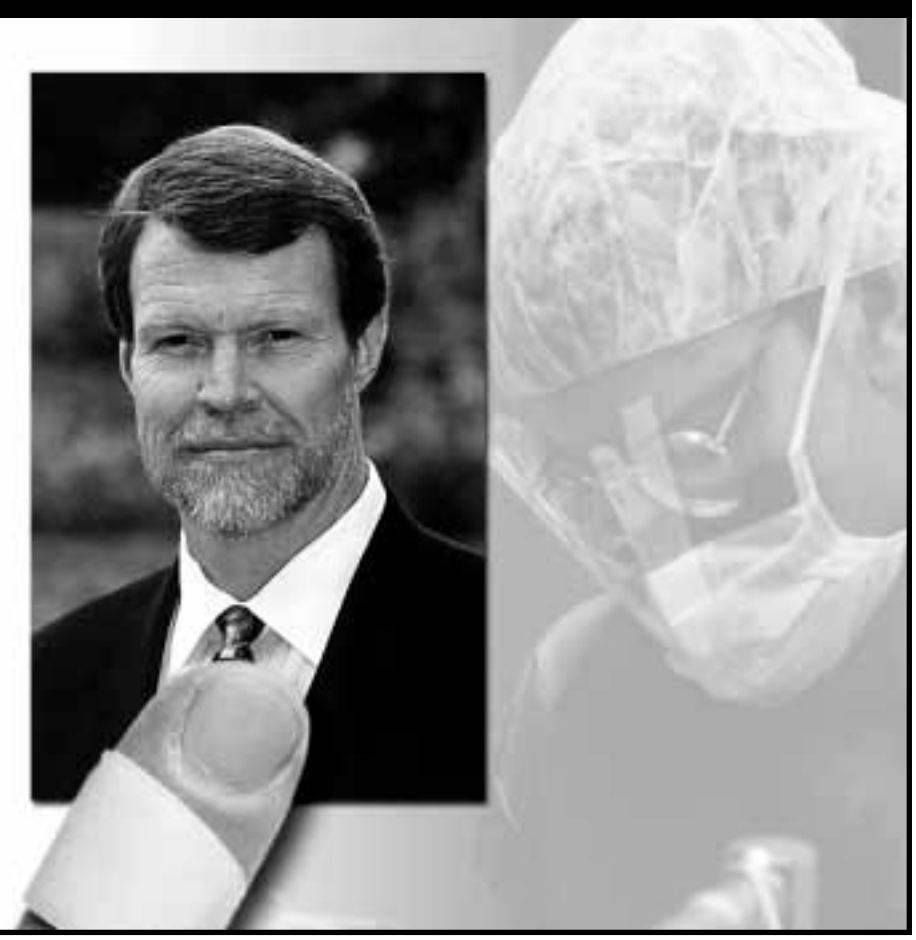

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Choice in Europe

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hierarchy, and top-down attitudes to one having diverse providers, networks, and consumer power has been most striking in Stockholm.

All over Sweden, consumers have gained access to a health care market that allows individuals to use public funding for treatment throughout the country. The number of contracted private health care providers has risen, reflecting consumer choice and the apparent preference of many young doctors and nurses to work for private contractors.

Stockholm's revolutionary approach—public funding, public-private cooperation, and freedom of choice—has begun attracting international attention. National and regional officials from Canada, Norway, the Netherlands, Germany, Japan, and the UK have visited Stockholm to analyse the outcomes.

Britain Follows Suit

The most striking consequence so far has been the British government's recent decision to modify its National Health Service (NHS). The NHS is slowly being reformed from a monopolistic and bureaucratic entity into a more decentralised agency with greater consumer focus.

Much of New Labour's plan will have a familiar ring to Stockholmers. Waiting periods for treatment are to be reduced to three months at most (equivalent to those in the Stockholm region), though not until 2008. "Perverse incentives" within the NHS are to be replaced with constructive ones. Hospitals are to be paid for what they actually deliver—as is the case with Stockholm's Diagnosis Related Groups (DRG) system (which is itself akin to that of the U.S. Medicare programme).

The DRG system allocates a price to every diagnosis or treatment and compensates hospitals only once the service has been delivered. In Stockholm, this step has dramatically reduced waiting lists. British patients will be able to choose freely among health care providers, in order to reduce waiting times and improve quality.

As in Stockholm, health care authorities will be required to inform people of the options available to them. To strengthen freedom of choice and expand supply, publicly funded private care providers are to be contracted, as in the Stockholm County Council (Sweden's elected regional authority responsible for funding and delivery of health services).

Independent hospitals are also to be introduced under NHS auspices, as is already the case in Stockholm. With this combination of decentralisation, consumer influence, and productivity incentives, the UK government hopes to remould the NHS.

Switching from Government Care

But the Stockholm County Council is not the only source of inspiration. Elements of Sweden's national model are now also being exported. Local authorities, for example, are to be made financially responsible for so-called "bed-blockers" (elderly patients who remain in hospital beds longer than is medically necessary because they do not have access to long-term care).

Budgeting responsibility is to be moved down to Primary Care Trusts, freestanding bodies within the NHS responsible for commissioning and providing community health care services. These Trusts will in the future control 75 percent of all NHS funding allocations, along the same lines as Swedish County Councils.

Norway, Denmark, and Finland could also benefit from the Stockholm approach. Basic financial incentives and options for workers to start their own businesses could revolutionise the delivery of health care in eastern Europe. Sweden's independent hospitals are already attracting interest in the Netherlands and Germany.

In the future, health care consumers in the developed world will become less and less tolerant of long waiting lists, inadequate information, and lack of influence. The new Swedish model—consumer-driven, and incorporating positive economic incentives—is the future of health care. Governments neglect it at their peril.

*Johan Hjertqvist is director of the Timbro Health Policy Unit. Timbro (***www.timbro.com***) is a free-market think tank based in Stockholm, Sweden. A longer version of this article was first published in the Pfizer Forum,* **http://www.pfizer.com**.

"Every time the government attempts to handle our affairs, it costs more and [the] results are worse than if we had handled them ourselves."

Benjamin Constant, Nineteenth century French political scientist

Kuehl-Care Wrong for Californians

Measure would be costly, counterproductive, and a danger to the well-being of all Californians

Sally Pipes

A new plan for a system of government health care in California is being touted by its author as a grand idea. That is a strange description for a measure that would be costly, counterproductive, and a danger to the well-being of all Californians.

The Health Care for All Californians Act, introduced by State Senator Sheila Kuehl (D-Santa Monica), would eliminate private health insurance. A Commissioner of Health would head a State Health Agency, and government boards would make key health care decisions for California residents.

The package is billed as free medical care, covering all state residents. In the first two years there would be no deductibles or co-pay. Under the plan, Californians would receive any procedure or treatment that a doctor or hospital says is medically appropriate, including dental and vision care, skilled nursing care after hospitalization, "self-help programs," and "translation services."

Disaster in the Making

Under the Health Care for All Californians Act, the state would pay all the bills, though Kuehl says the plan involves "no new spending." Since no service, particularly medical care, can be free, the government would have to get the money from new payroll taxes on "all employers, employees, the self-employed, and recipients of unearned income."

The act also levies new taxes on tobacco and alcohol products. No tax rates are mentioned in the bill, and residency requirements for participating in the program are not outlined.

For most Californians, this measure would be a disaster. The state is

STATE SENATOR SHEILA KUEHL

more than $35 billion in debt and cannot pay for the programs it currently funds, much less new ones. California is already one of the nation's highest taxed states, and

"Kuehl is right that too many people lack health insurance, but wrong to seek a solution by eliminating HMOs, PPOs, and private insurance, expanding bureaucracy, and increasing taxes."

new levies would cause more workers and businesses to flee.

Since government bureaucrats would be under pressure to reduce costs, this system would stifle innovation, reduce quality, and further limit people's choices. That is precisely what has happened in Canada, where waiting lists are common and costs high. Since private alternatives are banned there, the only recourse for many is to seek care in the United States.

Fraud, already rampant in Medi-Cal, would thrive under a massive state bureaucracy that hands every resident a blank check for health care. The plan provides no incentive for people to take care of themselves and would encourage irresponsibility.

Private Sector, Choice

Given the dismal record of government-run health care in the United States and around the world, it is amazing a plan like Kuehl's could be conceived at all, let alone be taken seriously. Countries such as Sweden and Britain, where state medical care has long been the status quo, are moving to private alternatives.

Kuehl is right that too many people lack health insurance, but wrong to seek a solution by eliminating HMOs, PPOs, and private insurance, expanding bureaucracy, and increasing taxes. Many people also lack car insurance, but the answer is not a government takeover of the automobile insurance industry.

If state legislators want to improve quality of care, restore the doctor-patient relationship, and increase the number of insured, health care must be made portable and not tied to a place of work. Individuals must have more, not fewer, choices in the health care marketplace.

Sally Pipes is president and CEO of the Pacific Research Institute, a California-based think tank. Her email address is ***spipes@pacificresearch.org***.

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Heart Problems Reported in Smallpox Vaccine Recipients

No link established between vaccine and health risks

Conrad F. Meier

Two women, both first-responder health care workers in their 50s, have died of heart attacks suffered after receiving vaccinations against the smallpox virus. A 55-year-old National Guardsman with a history of coronary artery disease also died of a heart attack days after receiving the vaccine.

Five other individuals have developed heart-related conditions after receiving the smallpox vaccine, including one additional heart attack, two cases of angina or chest pain, and two cases of myopericarditis, an inflammation of the heart muscle or sac surrounding the heart. In addition, 10 military personnel are known to have developed myopericarditis after being vaccinated.

None of the reported heart problems has been linked directly to the vaccinations, although research is ongoing. Dr. Walt Orenstein, director of the National Immunization Program of the U.S. Centers for Disease Control and Prevention, says the evidence may suggest the vaccine is playing a role in the myopericarditis, particularly based on the military data.

"The data from the civilian side from the heart attacks," says Orenstein, "and from the cases of angina are within what we might have expected from chance alone."

One of the civilian women was 50 years old and had a history of hypertension and smoking. She was vaccinated on March 18, developed chest tightness, dizziness, nausea, and vomiting on March 22, and died 24 hours later. A preliminary autopsy indicated a heart attack.

The second woman, identified by the *St. Petersburg Times* as Virginia Jorgensen, a nurse's aide in St. Petersburg, Florida, was 57 and also had a history of hypertension and smoking. Jorgensen had undergone a previous cardiac catheterization, during which she had suffered a mini-stroke.

First-time Recipients

All of the cases of myopericarditis occurred among individuals who had never before been vaccinated against smallpox, indicating they were born after 1972, when smallpox vaccinations for the general population were halted.

There have been no reports of adverse events among military personnel who were previously vaccinated. "It's only in the first vaccination group that this is occurring," the CDC's Orenstein said. All have recovered, Orenstein said, and are back at their regular duties.

There have been reports of myopericarditis following smallpox vaccination in the past, but the majority of the reports came from Australia and Europe, where a different strain of the vaccine was used. "Heart problems were not scientifically accepted adverse events of the smallpox vaccine," Orenstein said. "Certainly there may be occasional reports of this, but not enough to support a role for the vaccine."

Meanwhile, the CDC appears to be proceeding with the second phase of its smallpox vaccination program, which calls for voluntary vaccination of all nationwide health care and public safety workers such as firefighters and police.

Warnings Expressed

The Advisory Committee on Immunization Practices, which advises the CDC, has recommended the list of people who should not take the vaccination be expanded to include heart patients and persons at risk of heart disease.

The Institute of Medicine (IOM) has urged the CDC to take a careful look before proceeding and recommends the CDC "comprehensively evaluate the program and its outcomes in order to improve its implementation and to protect the vaccinees and the public." The committee's report recommended a pause between the first and second phases of the vaccination program.

Dr. Brian Strom, chairman of the IOM committee, told media representatives, "Efforts from here on in should be focused on what is needed for preparedness. This is an opportunity to recalibrate and redirect the program to make sure the focus is on what is really needed in the future."

Federal officials had planned to offer the vaccine on a voluntary basis to at least 450,000 civilians in the program's first month. After two months, only about 25,000 have been vaccinated, with many hospitals opting out of the program.

The CDC is working to improve the numbers, but after learning of the first death, officials decided anyone with a history of heart disease should not get the vaccine. The Pentagon adopted the same policy.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org.**

AFP

Nurse manager Audry Goto (R) vaccinates public health care nurse Rita Bagby (L) with the smallpox vaccine as the Los Angeles County Department of Health Services starts to administer the vaccine as part of its on-going bioterrorism and public health emergency readiness.

INTERNET INFO

Visit the CDC Web site at **www.cdc.org** and the Department of Health and Human Services' Web site at **www.hhs.gov**.

Smallpox

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ity, and went down to defeat 206-184. "The White House wanted us to put it on the suspension calendar. We warned them this could happen," DeLay said.

In Opposition

Democrats, 21 Republicans, and groups representing nurses and other "first responders" said the plan was not generous enough to ease the fear of health care workers, who worry they may not be adequately compensated if they suffer severe side effects from the vaccine. Experts estimate between 15 and 50 people of every 1 million vaccinated for the first time will face life-threatening complications, and one or two will die.

Democratic leaders urged Republicans not to try to attach the measure to the war spending bill. "I would hope they would not put their ill-advised bill that didn't even get a majority into a must-pass bill" like the spending measure, House Majority Leader Nancy Pelosi (D-California) told reporters. But Pelosi and House Majority Whip Steny Hoyer (D-Maryland) also said they thought the tactic could work, since most Democrats plan to vote for the bill to provide additional spending for the war and other homeland security efforts.

A Senate committee is scheduled to continue debate on its version of a smallpox compensation program. Despite weeks of negotiating, Health, Education, Labor and Pensions Committee Chairman Judd Gregg (R-New Hampshire) has been unable to reach agreement with Edward M. Kennedy (D-Massachusetts).

"There's some basic issues we can't agree on," said a spokesperson for Gregg. A Kennedy spokesman said the senator planned to offer amendments to make funding for the program automatic, rather than subject to annual appropriations; to eliminate the Senate-proposed $50,000 cap on lost wages; and to allow workers to collect lost wages even if they are out of work for fewer than five days.

Compensation Conundrum

Some Democrats want more generous compensation. Kennedy said the bill is a "tin cup response to a major kind of health threat, and it insults first responders in this country." Gregg said the $262,100 lump sum death benefit is equal to the amount paid to survivors of police officers killed in the line of duty, and more than the $256,000 paid to survivors of fatally wounded soldiers.

Gregg also pointed out, "This is not a legal issue. This is not a health issue. This is a national security issue. We are at war. The passage of this legislation is vital to the safety of the American people."

Republicans believe approving a compensation bill would substantially increase participation in the administration's plan to vaccinate 450,000 health care workers. While 350,000 military personnel have been vaccinated, according to the April 7 issue of *U.S. News & World Report*, as of April 4, only 25,000 health care workers have received the vaccine.

"We've got to get this program in place to immediately lower the barriers" to participation, said Senate Majority Leader Bill Frist (R).

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INTERNET INFO

See "Thumbs Down on Smallpox Vaccine Program," *Health Care News*, April 2003, available on the Web site of The Heartland Institute at **http://www.heartland.org/Article.cfm?artId=11797**.

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SARS Lessons for U.S.

Sydney Smith

It's been almost two months since SARS, the Asian "mystery pneumonia," burst onto the world scene, yet already so much has changed.

The causative agent is now believed to be an especially virulent form of a common cold virus—the coronavirus. Why this one is so virulent no one yet knows. We know it started in China and spread to Hong Kong and from there to all points around the globe. We know it's highly contagious, just as a cold is.

The WHO physician responsible for the initial investigation succumbed to it. We know it has an incubation period of up to 10 days; it starts like the flu, with fever, chills, and muscle aches; and after three to seven days it progresses to a cough and shortness of breath; in up to 20 percent of cases, the shortness of breath is bad enough to require ventilator support. We know we have no effective treatment yet, beyond supportive care. And we know the mortality rate is around 4 percent.

"The CDC needs to study the lessons of Hong Kong during the SARS epidemic, and take a long, hard look at current smallpox vaccination policies. There is such a thing as being prudent to a fault."

We also know this: SARS has been difficult to control in Hong Kong because so many health care workers have been infected. Shortly after the outbreak started, emergency rooms and hospital wards were full of doctors and nurses ... as patients. Incapacitated health care workers mean fewer people to treat the very sick—and fewer people to decide who needs to be quarantined. Not surprisingly, outside of China proper, Hong Kong has had the highest number of cases, and the highest number of deaths.

A Lesson for the U.S.

There's a lesson to be learned here, and one we ignore at our peril. If an infectious disease with only a 4 percent mortality rate has wreaked so much havoc on Hong Kong's health care system, imagine what a disease with a higher mortality rate would do. Say, a disease with a 30 percent mortality rate—a disease like smallpox.

Even as this lesson plays itself out in Hong Kong, efforts in the U.S. to prevent just such a scenario in the event of a smallpox bioterror attack are stalling. Three states—Illinois, New York, and California—and several hospitals have put their pre-attack vaccination plans on hold.

The reason? Nationwide, three people died of heart attacks within a few weeks of receiving the vaccine. Three people out of more than 125,000 vaccine recipients. Two of them were known to have coronary artery disease. The other was a middle-aged man who smoked and had high cholesterol. If none of them had been vaccinated, their heart attacks would have raised nary an eyebrow.

There is no reason to suspect smallpox vaccine caused these heart attacks. In the almost two hundred years that the smallpox vaccine was in widespread use, there were no reports of an association with heart attacks. It has been known to cause an infection of the heart muscle (myocarditis) or the lining around the heart (pericarditis), but neither condition causes heart attacks.

Yet, because the CDC is not only tracking every single event that occurs after a vaccine (as is proper in their role as epidemiologists), but also notifying the media about every single event, no matter how remotely related (not so proper or wise), the smallpox vaccine is being unfairly characterized as more dangerous than it is.

The CDC has gone even farther. To eliminate as much risk as possible, they've recommended that people with a history of heart disease forego the vaccination. CDC officials may consider this only a prudent precaution, but in the eyes of the media and the public, it's seen as an admission of cause and effect. As a result, we get media reports that smallpox vaccine is "linked" to heart attacks, although there is absolutely no evidence of that. Transparency is an admirable goal, but elevating coincidences to the level of definite risks is not.

In Perspective

Consider the influenza immunization. Here's an immunization that's routinely given to those at highest risk for heart attacks: the elderly and those with heart or lung disease. Surely, people have fatal heart attacks within a few weeks of receiving it. Surely, that number is far higher than the three who had heart attacks after getting smallpox vaccinations. But there's no way of knowing that number.

No one would ever report it as an adverse event under those circumstances. It would be an expected unrelated event. So it is with smallpox vaccine. Its adverse events should be monitored the same way we monitor adverse events for other immunizations. Only when there is a clear association with the vaccine and a bad outcome, should steps be taken to curtail its use.

The CDC needs to study the lessons of Hong Kong during the SARS epidemic, and take a long, hard look at current smallpox vaccination policies. There is such a thing as being prudent to a fault.

Dr. Sydney Smith is board certified by the American Board of Family Practice, a fellow of the American Academy of Family Practice, and publisher of MedPundit. This article was first published by Tech Central Station (**http://www.techcentralstation.com**) *on April 1, 2003 and is reprinted here with permission.*

Reuters

Children wear masks to protect themselves against Severe Acute Respiratory Syndrome (SARS) during an ice-skating lesson in Hong Kong on April 6, 2003. Some hotels in Hong Kong are refusing to check in people from mainland China, and some doctors are not treating patients suffering SARS-like symptoms unless hospitals certify they are free of the virus.

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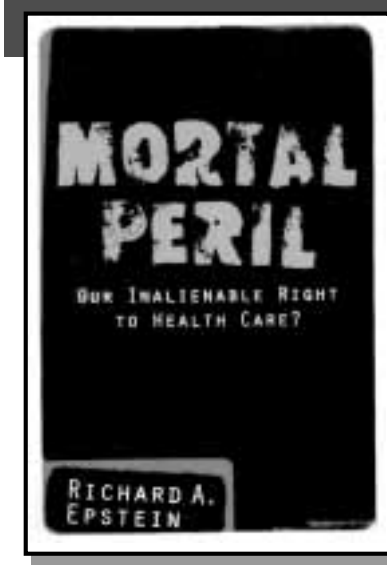

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SCANDLEN**AT LARGE**

Consumer Choice Matters

Greg Scandlen

The National Governors Association (NGA) and the National Association of Insurance Commissioners (NAIC) are in the forefront of opposition to Association Health Plan (AHP) legislation now before Congress. Yet these two organizations are largely responsible for the chaos in the small group market today.

Both groups jumped on the idea of "small group reform" in the late 1980s and early 1990s, despite warnings at the time that such regulations would strangle the market, drive out competitors, and raise costs dramatically. All of these predictions have come to pass.

The mass of regulations—including mandated benefits, rating restrictions, prompt payment laws, any willing provider laws, market conduct regulations, premium taxes, and many more too numerous to count—have made it impossible for the insurance industry to deliver low-cost coverage to their small business clients.

Employers and their employees are suffering the effects and have turned to Congress for relief. They are asking Congress to allow the creation of AHPs to gain some of the same protection against excessive state regulations that larger, self-insured employers enjoy.

If the NGA and NAIC are opposed to this initiative, they hold the solution in their hands. All they need do is roll back the regulations that created this mess. About half of the governors and insurance commissioners are brand new this year. They don't need to defend the idiotic ideas of their predecessors. If they want to continue having the states control the insurance market, they have an obligation to move decisively to eliminate the causes of the problems. Some state legislatures are working on exactly that, as reported below.

Rollback: No Willing Provider in Washington

Peter Neurath reports in the *Puget Sound Business Journal* that an effort is underway in Washington state to repeal "the law (that requires) insurers to cover the services of every category of provider including chiropractors, naturopaths, acupuncturists, and massage therapists."

The story cites Regence Blue Shield as saying these providers cost the company $44.5 million in 2002 alone, up from $20 million in 1999, $30 million in 2000, and $35 million in 2001.

The local chiropractic association is opposed, saying, "If a provider can legally do a service, within the scope of their practice, then people should have a right to select that provider." Of course that's true, but people should also have the right to select an insurance plan that covers only what they want to have covered.

Rollback: Opting out in Georgia

Small businesses in Georgia are also pushing for relief, according to Debbie Gilbert in the *Gainesville Times*. Senate Bill 50 would allow employers to buy a package without including Georgia's 12 mandates. Insurers would still have to offer a plan that included these mandates, but employers could opt out of them.

State Sen. Renee Unterman (R) is identified as a registered nurse who worked to get some of the mandates passed. She says, "It's a double-edged sword. Those mandates are important. But in these hard economic times, we need to do something to make insurance more accessible and affordable."

Rollback: Mandate Free in Florida

Florida's insurance commissioner Tom Gallagher didn't wait for legislative action. On February 27, he issued a directive requiring all carriers in the market to offer an insurance plan that is free of the 52 state mandates. Small employers will be allowed to "pick and choose" from a menu of options. An article by Chris Kauffmann in the *Fort Pierce Tribune* estimates the new approach could save as much as 40 percent of premium costs. Business leaders in the area are described as "surprised and pleased" by the development.

The directive also requires MSA-compatible deductibles, wider cost-sharing options, some prescription drug and transplant coverage, and coverage of "urgent care centers" as an alternative to emergency rooms. The department spokeswoman said the program could save between 20 percent and 40 percent of premium and encourage more carriers to re-enter the Florida market.

Employers Near Breaking Point in Wichita

In Wichita, insurance broker Gary Hardman says he "has never seen rates so high and climbing so fast," according to the *Wichita Business Journal*. He says when he first started writing coverage in 1977, a family plan went for $35 a month, while today it is between $750 and $800 a month. Hardman adds, "Employers are near the breaking point on premiums." None of his clients has dropped coverage yet, but he expects "significant fallout" if premium hikes continue to average 25 percent.

Switch from Community Rating Painful in Pennsylvania

In Pennsylvania, small employers may not be dropping coverage, but they are considering the cost of coverage in making hiring decisions, according to an article in the *Patriot News*. An applicant with a spouse and children is looking a lot less attractive than a single person due to the added coverage costs, according to Tom Fleischer of PIP Printing in Harrisburg. He says a family policy for one of his employees went from $467/month in 2002 to $613/month this year. The coverage includes a $500 per-person deductible and a 20 percent copayment on the next $1,000 per person.

The CEO of Capital Blue Cross says, "I don't see any let-up. I don't see anything that is going to change this." Part of the increase in Pennsylvania is due to a switch by the Blues from community rating to demographic rating, which the article says is "more fair because they allow groups with fewer medical expenses to pay less." The article points out that critics disagree, arguing community rating "keeps health insurance affordable for all, especially for older people who need more medical care and have less ability to pay."

One business owner, 58-year-old Alan Geoffrey, says the premium for his family went from $587 a month in 2002 to $987 a month this year. On the other hand, Eric Buck, a spokesman for the Pennsylvania Builders Association, says 60 percent of his members benefited from the change. He adds, "The issue of affordability is really beginning to reach a fever pitch," and 700 of his 6,300 members stopped offering coverage this year.

"About half of the governors and insurance commissioners are brand new this year. They don't need to defend the idiotic ideas of their predecessors."

No Painless Remedies

And in the *Atlanta Business Chronicle*, writer Julie Bryant sees "No painless remedies for the uninsured problem." She cites the recent Robert Wood Johnson Foundation report and says, "One in three Georgians were without coverage in the past two years." She says, "Small employers have cried out for tax credits to help ease the cost of health coverage for individuals, while others have touted medical savings accounts as a solid solution."

But Bill Custer of Georgia State University claims such ideas do nothing "to address the overall problem of rising health care costs." The article says Len Nichols of the Center for Studying Health System Change would prefer Congress "tackle the problems of waste and inconsistent quality of care in the health care system."

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *Please send all comments/questions directly to Scandlen at* **gmscan@aol.com.**

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FDA Crackdown

continued from page 1

Congress attempted in 2000 to legalize reimportation, but met a firestorm of opposition from former FDA commissioners and Health and Human Services secretaries. They warned imported drugs raise serious safety concerns since they could be counterfeit, contaminated, expired, or mislabeled. Black market rings inevitably spring up with swindlers and imposters entering the market.

A Florida grand jury says that's already happening along the southern borders of the U.S., where the state's wholesale pharmaceutical industry has been "corrupted by the infiltration of a criminal element which is making a fortune while tainting our drug supply." Sale and resale of counterfeit drugs through the state's Medicaid program is costing taxpayers millions of dollars.

Senior Protest

The FDA crackdown is the latest move in the international drug battles over importing drugs from Canada, where price controls and exchange rates can mean lower prices.

Recently, angry seniors organized a boycott of over-the-counter medicines and braved a knee-deep snowstorm to protest a decision by the British pharmaceutical company, GlaxoSmithKline, to stop selling its prescription drug products to Canadian pharmacies that export the medicines outside Canada.

Glaxo says it made its decision because it can't guarantee the safety of its products sold by Canadian mail-order pharmacies to the U.S. The Vermont legislature also joined the fray, passing a resolution condemning Glaxo. In an effort to shift the market to other companies, legislators voted to subject all of Glaxo's prescriptions to a review process before they could be prescribed through state-funded health programs like Medicaid.

No Legal Recourse

The U.S. FDA does not have jurisdiction in Canada and doesn't begin to have the personnel necessary to monitor every package of pills coming into the U.S. The agency suggests seniors should worry that no one is making certain they are getting the drugs they ordered, much less ensuring the safety of those drugs.

Canadian law doesn't protect them either. Article 37 of the Canadian Food and Drug Act says drugs imported into Canada but not intended for sale in Canada do not have to meet the same safety inspection standards. The president of the Canadian Medical Association, Dana Hanson, praised the FDA decision. "We feel Internet pharmacies could jeopardize patient safety, and we're against them."

"At least 80 Internet enterprises are operating in [Canada], employing about 2,500 people and grossing $500 million a year."

The Canadian pharmacy board, which recognizes its pharmacists are breaking U.S. law, has begun to help, punishing Internet pharmacies that fail to have a Canadian pharmacist "rubber stamp" a prescription by a U.S. doctor before it is filled.

If a U.S. citizen were to be injured by reimported drugs, pharmaceutical companies have no doubt trial lawyers would quickly file a class-action suit against them, saying they knew the drugs were being sold back to the U.S. illegally and therefore are responsible. Deaths already have occurred with drugs reimported from Mexico, and it is only a matter of time for Canada, they say.

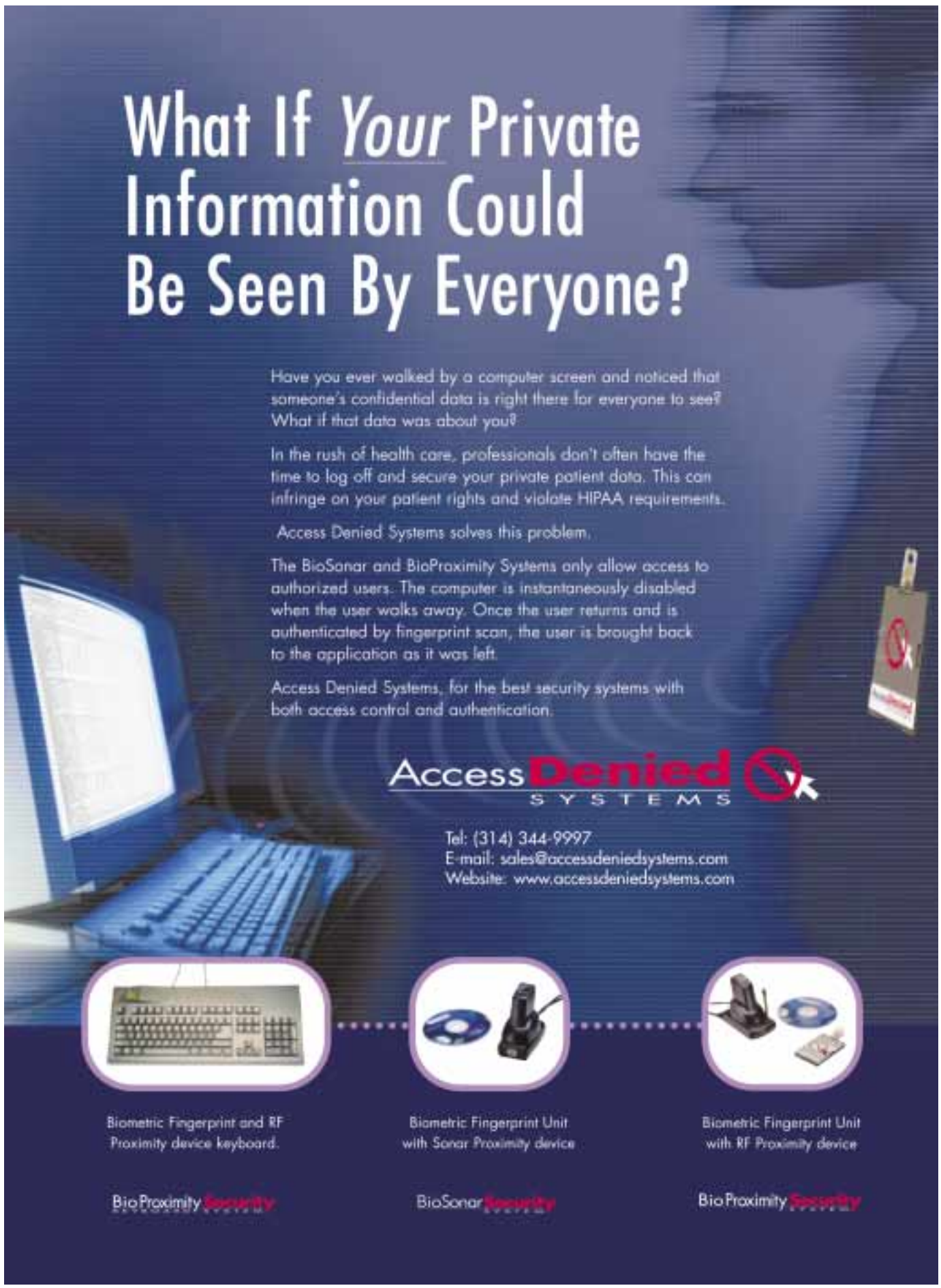
Follow the Money

Nonetheless, Canadian pharmacies have found that exploiting price controls and breaking U.S. law can be lucrative. At least 80 Internet enterprises are operating in the country, employing about 2,500 people and grossing $500 million a year. They soon may have to find other customers.

Health policy experts agree drug reimportation is not the best way for U.S. seniors to get access to affordable medications. Congress has the issue on the front burner this year, with the leadership hoping to pass by this summer a bill providing a Medicare drug benefit.

What seniors need, they say, is a modernized Medicare plan that includes prescription drug coverage so they don't have to resort to boycotts and illegal activity.

Grace-Marie Turner is president of the Galen Institute, a not-for-profit research organization that studies the health care marketplace, and contributing editor to Health Care News. *Her email address is* **galen@galen.org.**



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How the President's Health Care Plan Covers the Uninsured

Nina Owcharenko and Robert E. Moffit Ph.D.

Millions of Americans are without health insurance. President George W. Bush has proposed a number of positive policy initiatives that can reverse this situation and make health care coverage more affordable for millions of individuals and families.

Diverse and Dynamic Uninsured Population

According to the U.S. Bureau of the Census, 41.2 million Americans did not have health insurance coverage at some time in 2001. Roughly half of the members of this diverse population were uninsured for a period of six months or less, and about 40 percent were uninsured for a period of 18 months or more.

The overwhelming majority of the uninsured are young, between the ages of 18 and 34; more than 80 percent are part of a working family. They tend to be employed in small businesses and are concentrated in wholesale and retail trade industries, agriculture, forestry, fishing, mining, and construction. They are disproportionately minorities, largely Hispanic. While a substantial majority of these Americans are low-income working people, the fastest-growing element of the uninsured population is comprised of middle- to upper-middle-income families.

Although the majority of Americans have health care coverage through their place of work, lower-income working Americans are less likely to have employer-sponsored coverage. Americans get unlimited tax relief for the purchase of health insurance if—and only if—coverage is provided through their employer.

Discriminatory Tax Policy

In 2000, the tax exemption for employer-paid health insurance was estimated to be worth $126 billion.

Lower-income working Americans who do not or cannot get health insurance at their place of work have few choices; they can either purchase non-group coverage outside of their place of work (and do so with after-tax dollars) or go without coverage altogether.

Health care economists concluded long ago that the country's health care tax policy is inequitable and inefficient, and that it distorts the insurance markets and contributes significantly to the number of uninsured in the United States.

Policymakers should also take into account that the uninsured impose costs on the public—including the cost of government payments and programs and other public spending for health care. In a recent research paper, Urban Institute analysts Jack Hadley and John Holohan estimated, in 2001 dollars, the public paid $35 billion for uncompensated care, and that $30.6 billion of that was in the form of government spending.

As Hadley and Holohan explain: "We ... estimated that governments finance most of the uncompensated care received by the uninsured, spending about $30.6 billion on payments and programs largely justified to serve the uninsured and covering possibly as much as 80-85 percent of the uncompensated care costs through a maze of grants, direct provision programs, tax appropriations, and Medicare and Medicaid payment additions."

Most of this money comes from the federal government, primarily through Medicare and Medicaid, followed by state/local tax appropriations for hospitals, Medicaid DSH and UPL payments, and the Veterans Administration's direct care programs. Replacing this inefficient system with direct assistance to the uninsured would be simpler and cost-effective.

Expanding Coverage and Choice

President Bush proposes to address the needs of America's uninsured by fixing the inequities of the current system and mainstreaming uninsured individuals and families into the private insurance market. While liberal policymakers would like to enroll the uninsured in public programs such as Medicaid (which are, even now, overwhelmed and underperforming), surveys show Americans prefer private health coverage.

To achieve its mainstreaming objective, the administration would create a new system of tax credits for health care coverage targeting low-income individuals and families without employer-provided coverage. Bush also has proposed a series of reforms aimed at improving existing health care accounts. These policy recommendations would enable individuals and families to make their own decisions regarding health care and how to spend health care dollars.

Tax Credits

The President is resubmitting to Congress an $89 billion health care tax credit proposal to assist millions of Americans who are without health insurance provided through the workplace. The tax credit would provide a subsidy of up to 90 percent of the cost of a health insurance premium, up to a dollar amount of $1,000 per person and $3,000 per family.

Families with an adjusted gross income of $25,000 or less would be eligible for the maximum credit of $3,000. For families with incomes above $25,000, the amount of the credit would vary with income. The credit phases out at income levels of $30,000 for an individual with no dependents and $60,000 for families with children.

The proposed tax credit would be refundable, meaning low-income individuals and families who owe little or no taxes would still receive a subsidy for the purchase of health insurance. It

MORE INFORMATION

The complete text of *Heritage Foundation Backgrounder* #1636, with footnotes, is available on the group's Web site at **www.heritage.org/Research/HealthCare/bg1636.cfm**. It is also available in Adobe Acrobat's PDF format through *PolicyBot*. Point your Web browser to **www.heartland.org**, click on the *PolicyBot* icon, and search for document #**11956**.

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would also be "advanceable," meaning individuals or families would get the assistance at the time premium payment is due and not have to wait until the end of the year for reimbursement.

The Bush tax credit proposal outlines a new role for the states, both in building an infrastructure incorporating choice and competition and in providing additional subsidies for low-income Americans.

Under the terms of the original tax credit proposal outlined last year, the purchase of health insurance in the individual market would qualify a taxpayer for the credit. The new Bush proposal offers the tax credit not only to those who purchase a plan in the non-group market, but also to those who purchase health insurance through private-sector purchasing pools, state-sponsored insurance-purchasing pools, and state high-risk pools.

After December 31, 2004, the Bush plan gives state authorities the discretion to allow individuals and families who would not otherwise be eligible for public assistance to buy into certain state-sponsored purchasing groups where private insurance is offered or to buy into state government employee health-purchasing groups, and to receive a federal tax credit for doing so.

States also could supplement the federal tax credits used for group purchasing of private health plans. Under the terms of the Bush proposal, states could make an additional contribution of up to $2,000 per adult for those with incomes at 133 percent of the poverty level; this contribution would be phased down to $500 per adult for those with incomes that are 200 percent of the poverty level.

Health Care Accounts

The Bush administration has unveiled a broad range of policy improvements to make health care coverage more affordable by giving individuals greater control of their health care spending.

In 2002, the U.S. Department of the Treasury issued a ruling to clarify the status of health reimbursement arrangements (HRAs). Through these arrangements, employers could offer employees a health plan in combination with a tax-free spending account for health care expenses, allowing any unspent funds to be carried over from year to year, tax-free.

The Bush administration is also proposing statutory changes that would expand and improve Archer MSAs and FSAs. Changes in Archer MSAs are particularly significant, given that nearly 73 percent of MSA enrollees were previously uninsured.

Flexible Spending Arrangements

Under current law, employees can participate in employer-based FSAs, through which employees can set aside a portion of their salaries in a special, pre-tax account to use for anticipated qualified health care expenses. If employees do not use the funds they have set aside in their FSA by the end of the year, however, they lose them. They may not carry over any unused funds to the following year. Under the Bush proposal, employees could carry forward up to $500 of unused funds in their FSAs tax-free every year for medical expenses.

Medical Savings Accounts

Medical savings accounts, from which individuals and families can pay for their medical expenses, are tax-free and can be rolled over from year to year. Under current law, no more than 750,000 individuals can have a medical savings account, and the MSA demonstration is scheduled to end after December 31, 2003. These restrictions have discouraged the health insurance market from offering MSA products.

A number of statutory and regulatory restrictions also constrain how MSAs may be used. For example, under current law an MSA must be coupled with a high-deductible health plan. The law specifically defines a high-deductible plan as one with "deductible(s) in the range of $1,700 to $2,500 in the case of individual coverage, and $3,350 to $5,050 in other coverage arrangements, with out-of-pocket limits set at $3,350 for individual coverage and $6,150 in all other cases."

The Bush proposal would eliminate the artificial participation cap on MSAs and make the demonstration permanent. Those changes would remove market disincentives and allow supply to meet market demand. Bush would also open the MSA option to any individual who wanted one (with the exception of those who would otherwise be eligible for a refundable tax credit) and change the definition of a "high-deductible" plan to any plan with an annual deductible as low as $1,000 for an individual and $2,000 for family or other coverage, with an additional provision to encourage preventive medical services.

"President Bush's health care policy agenda is laudably ambitious. It would make health care coverage more affordable and would help millions of Americans secure health insurance coverage."

The Bush plan also would allow both employers and employees to contribute to the account—today only one or the other may do so—and would permit contributions up to 100 percent of the annual deductible; contributions are currently capped at 80 percent of the deductible.

Conclusion

The problems of the uninsured are symptomatic of a deeper problem affecting the country's health care system: the federal and state tax treatment of health insurance. The current system undermines the portability of insurance, inhibits personal ownership and control of health plans, prohibits genuine consumer choice, and obstructs the functions of the market.

President Bush's health care policy agenda is laudably ambitious. It would make health care coverage more affordable and would help millions of Americans secure health insurance coverage. The President's policy would ensure the expansion and availability of private health insurance coverage for individuals and families.

The President's proposals establish a high bar for success. With the help and support of Congress, the bar can be reached—and, in some cases, raised even higher.

Robert E. Moffit Ph.D. is director of the Center for Health Policy Studies and Nina Owcharenko is health care policy analyst at The Heritage Foundation. This analysis was first published on March 11, 2003 as Heritage Foundation Backgrounder #1636 and is reprinted here with permission.

Improving on an Ambitious Proposal

Nina Owcharenko and Robert E. Moffit Ph.D.

The President has laid out an ambitious health care policy agenda that includes substantial revisions in the federal tax code and the federal tax treatment of health insurance. Additional reforms, however, would improve the plan.

1. Permit states to determine the level of tax credit supplement and allow employers to contribute. The Bush proposal allows states to supplement the federal tax credit. However, the plan limits the amount states may contribute and whom they may assist. States should be given the flexibility to leverage all available resources to enhance the federal tax credit as they see fit for their residents. For employees who are not receiving employer-sponsored coverage, regulatory policy should be amended to permit employers to make a contribution on behalf of their employees.

2. Provide a partial tax credit for employer-sponsored health insurance. While a number of uninsured workers do not have access to employer-sponsored coverage, some are offered employer coverage but decline it because of the cost. The Bush plan provides no assistance to low-income families who must make a financial commitment to get insurance through their employer. To promote equity, certain income-eligible individuals should be able to receive a partial tax credit that can be applied to an employer-sponsored policy. This might also encourage some small businesses to offer coverage. According to a recent survey, "75 percent of uninsured small employers said they would consider offering a health plan if the government provided tax credits to workers to help them pay for coverage."

3. Expand the FSA carryover to include all unused funds. There should be no limit on the carryover amount of unused FSA funds. Monies contributed to an FSA are set aside from the employee's earned wages. FSA funds are the employee's money; any unspent dollars in FSA accounts should be carried over year to year. Workers would be able to save for future, unexpected, or uncovered services, instead of trying to guess how much they will spend on medical expenses in a given year.

4. Establish individual ownership of HRAs. Currently, employers control health reimbursement arrangements, including the accounts. While employees are able to carry over unspent funds from the account year to year, when an employee leaves his or her job, the employer controls the account funds. Some employers give their employees access to any funds remaining in the accounts after they leave. But an employer need not do so, so employees have every incentive to "spend down" the funds in the account before separating from the company. That promotes wasteful spending. A better solution would be to give employees control and ownership of these accounts so that, upon their departure, they would be able to maintain the HRA policy on their own and continue to have full access to the account.

5. Expand the use of re-employment accounts for health care-related expenditures. President Bush has proposed establishing re-employment accounts for certain unemployed workers. These would be worth up to $3,000 and could be used to purchase training and supportive services. Since most workers lose their health insurance when they lose their jobs, unemployed workers should also be allowed to use these re-employment accounts to assist with health care-related costs, including premium payments on a health insurance policy, during their period of unemployment.

Robert E. Moffit Ph.D. is director of the Center for Health Policy Studies and Nina Owcharenko is health care policy analyst at The Heritage Foundation.

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NAHU Conference Attracts 600+ to Washington, DC

Conrad F. Meier

Patriotism was clearly evident as Rachel Saltzman opened the 13th Annual National Association of Health Underwriters Capitol Conference in Washington, DC with a rousing vocal rendition of the "Star-Spangled Banner."

Susan Rash, vice chair of NAHU's Legislative Council, welcomed 600+ health insurance professionals to the three-day event, held March 23-25, and introduced Dr. Stuart Butler, vice president of domestic and economic policy for The Heritage Foundation.

Down Mexico Way

Speaking from 25 years of experience with the British National Health Service (NHS), native Briton Butler addressed the myths and realities of single-payer health care systems.

The biggest attraction of single-payer systems is also the biggest myth, said Butler. "British citizens are told they have no worries. The government will take care of everything." The promises fall short, Butler noted, once a single-payer plan is implemented. Then rationing sets in, and patients experience long waits just for a visit with their primary care physician, then further waiting before they can see the recommended specialist, and then even more waiting to get into a hospital for treatment.

"Single-payer can only function if there is a parallel, private health care system in place," Butler said. "In Canada the parallel system is the United States. Canadians cross the border to escape the rationing and the wait."

"In Britain," he explained, "the parallel system is the private sector, paying cash, or contracting for health care in other countries. So, imagine America with a single-payer system. Where is the parallel system? In Mexico?"

Butler concluded, "It is crucial to pass health care insurance tax credits and legislation that empowers all consumers in order squelch the single-payer movement."

Legislative Priorities

Janet Trautwein, NAHU vice president for government affairs, took to the podium and laid out the organization's key legislative priorities for 2003. Among the issues she discussed were the uninsured, high-risk pools and the Trade Adjustment Act, Medicare reform, long-term care, medical savings accounts, medical malpractice reform, the patients' bill of rights, and association health plans.

Trautwein's briefing proved vital to the NAHU members who, later in the conference, went to Capitol Hill to meet with their senators and representatives.

Break-Out Sessions

Kelly Loussedes, NAHU's director of public affairs, moderated sessions addressing the topic, "Working with the Media." Guest speaker Bob Rosenblatt, 25 years with the *Los Angeles Times* and now a freelance editor and writer, offered valuable insights into the "do's and don't's" of working with reporters.

"If you want to get quoted, get your name in a reporter's Rolodex," said Rosenblatt.

Greg Scandlen, assistant editor of *Heath Care News* and director of the Center for Consumer-Driven Health Care at the Galen Institute, drew a standing-room-only crowd of NAHU members keenly interested in "Consumer-Driven Health Care: New Tools for a New Paradigm."

Scandlen focused on the essential problems in health care today, noting "Third-party payment leads to excess consumption, which leads to runaway costs, which leads to third-party rationing, which leads to limited supply, which leads to consumer discontent, which leads to government interference."

Additional sessions addressed controlling drug costs in health plans, long-term care, and the impact on insurance agents of HIPPA privacy laws.

Movers and Shakers

On day two of the conference, a parade of movers and shakers in health care policy stepped up and informed an attentive audience. Tommy Thompson, secretary of Health and Human Services (HHS), outlined President Bush's agenda on health care.

Thompson concluded by inviting participants to visit the department's state-of-the-art command center, saying, "I would just like to point out that the Department of Health and Human Services, as far as bio terrorism [is concerned], is very well prepared."

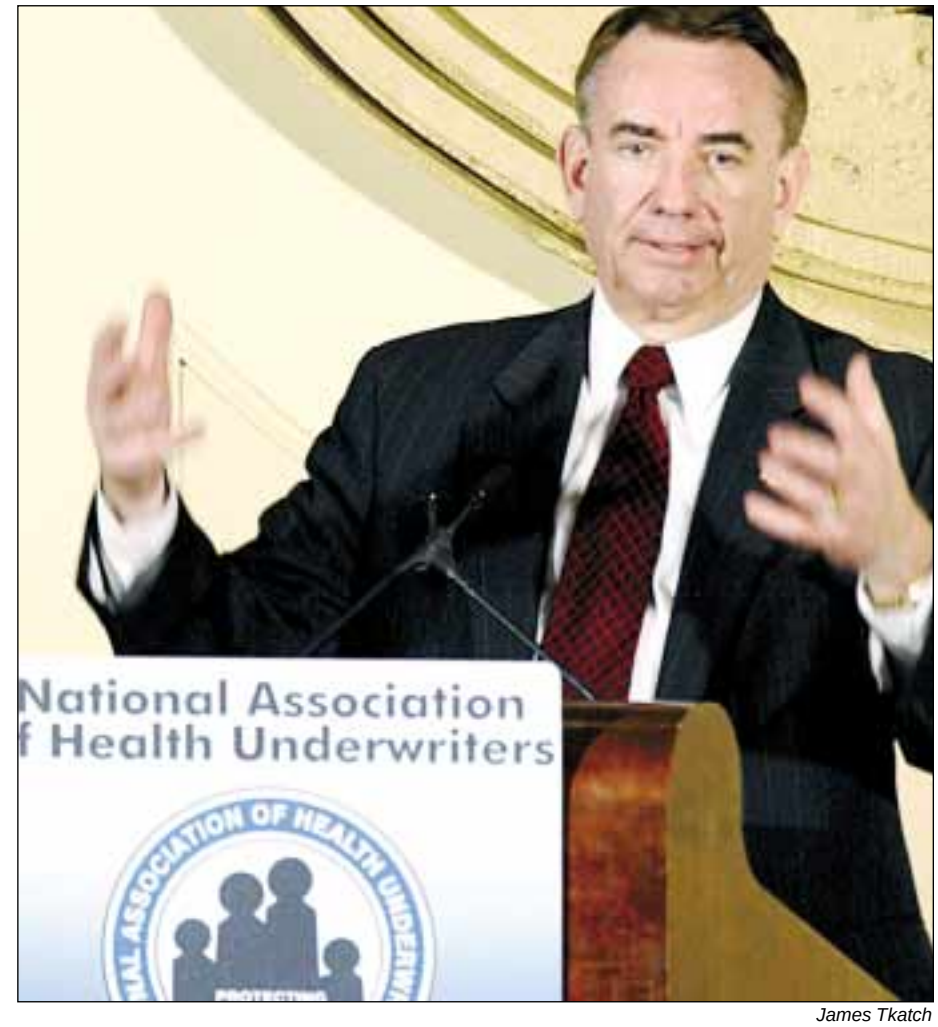
Dr. Mark McClellan, commissioner of the Food and Drug Administration, addressed the "Outlook on Drug Costs and Availability." McClellan said he considers it imperative that the FDA find ways to improve the drug approval process so that life-enhancing drugs can reach consumers sooner and less expensively.

Len Nichols, vice president of the Center for Studying Health Systems Change, gave the NAHU group a surprisingly humorous "Economist's Outlook on the Uninsured." The full text of a more serious paper upon which his remarks were based, *The Nongroup Health Insurance Market*, is available online at **http://www.healthaffairs.org/WebExclusives/Nongroup_Web_Excl_102302.htm**.

Off to the Hill

With the formal activities concluded, the NAHU regional associations gathered for their annual trip to Capitol Hill, newly armed with the information they needed to persuade lawmakers to pass effective and consumer-directed health care legislation.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.



James Tkatch

Tommy Thompson, Secretary of the U.S. Department of Health and Human Services, described President Bush's health care reform proposals to 600+ health insurance professionals attending the 13th Annual National Association of Health Underwriters Capitol Conference.

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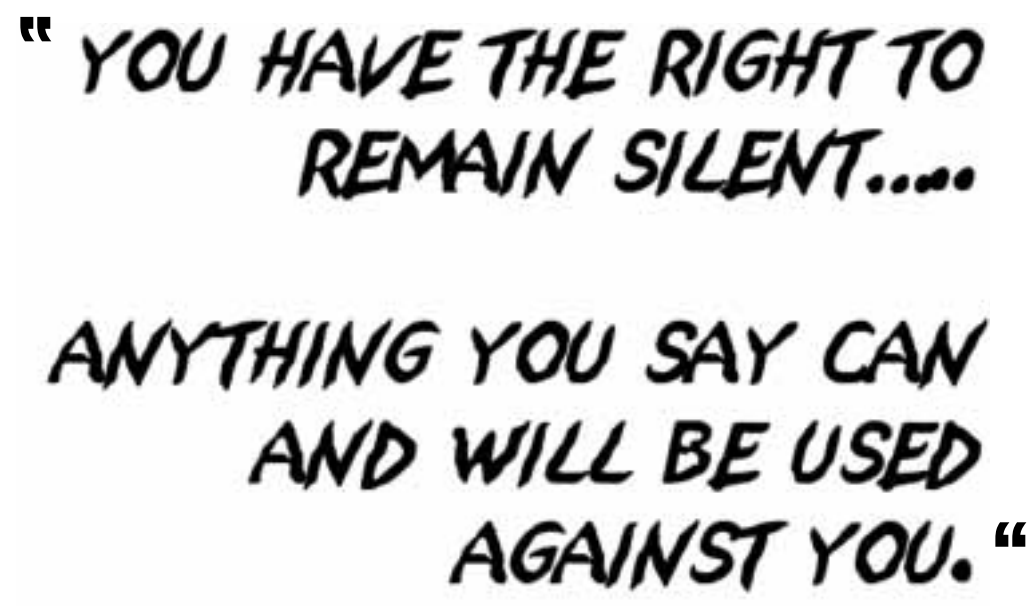

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STATE UPDATE

Compiled and edited by Conrad F. Meier

Spotlight on VERMONT

Medical Marijuana Bill Advances

A bill that would allow people with serious illnesses to legally possess and use marijuana passed the Senate with broad bipartisan support and is in the House for consideration. The 22-7 vote came after senators amended the bill requiring minors under age 18 to have a parent or guardian sign the application to participate in the medical marijuana program. Supporters of the bill claim it does not change marijuana's status as an illegal drug.

Sen. John Bloomer (R-Rutland) insisted, "I must be clear. We are not legalizing marijuana. We're creating an exception for an individual to receive treatment."

The bill requires a doctor's certification the patient suffers from one of several specified conditions, or from diseases like AIDS and cancer. Medical marijuana users would be allowed to use the drug only at home; they or their caregiver also could grow medical marijuana in a locked indoor facility and transport it in a locked container.

Some observers wondered whether the bill was needed, pointing out there have been no reported cases of police and prosecutors going after sick Vermonters using marijuana. "It seems to me we have a problem in the closet, and we seem determined to bring it out of the closet," said Senator Hull Maynard (R-Rutland).

House leaders say there is uncertainty whether the bill can clear that body, though a similar measure passed in the last session when Republicans held a wider margin. Governor James H. Douglas (R) has indicated he opposes the measure, but he stopped short of using the word "veto."

Eight states—Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington—have similar laws.

Vermont Press Bureau
March 17, 2003
Lexis/Nexis Research
March 31, 2003

COLORADO

ACLU Challenges Medicaid Cuts

The American Civil Liberties Union of Colorado filed a lawsuit attempting to prevent the state from balancing its budget by ending Medicaid benefits for thousands of immigrants. The class-action suit, filed on behalf of eight documented immigrants, seeks to block implementation of a law (SB 176) that reduces state funding for Medicaid by $1.3 million this year and approximately $8 million in 2004.

The law, which took effect April 1, ends Medicaid benefits for an estimated 3,500 documented immigrants. The suit contends the cuts are unconstitutional because they discriminate against documented immigrants who qualify for Medicaid benefits under federal law.

"The new law singles out sick and elderly legal immigrants who desperately depend on this assistance for vital medical care," Mark Silverstein, legal director of ACLU of Colorado, said. Karen Reinertson, director of the state division administering Medicaid, did not respond to *Health Care News* requests for an interview.

Rocky Mountain News
March 28, 2003

CONNECTICUT

Adults Will Lose SCHIP Coverage

The Department of Social Services sent letters to 23,000 adult residents, informing them they will no longer receive health coverage under the State Children's Health Insurance Plan, called the HUSKY program. Some adults in the program, parents of the 206,500 children in the program, lost their health benefits April 1 because of cuts made to reduce the state budget deficit.

All children in the health care welfare program and about 66,000 parents will continue to receive benefits. The state expects to save $12 million this fiscal year and $50.7 million next fiscal year because of the cuts, David Dearborn, a spokesperson for the department, said. "Expenditures and enrollments were increasing. The program was curtailed because of the state's budget and revenue crisis," Dearborn explained.

Governor John Rowland (R) has allocated $60 million in each of the next two fiscal years for hospital emergency room aid to compensate for additional costs that may result from adults seeking care in emergency rooms and community health centers.

Connecticut Post
March 17, 2003

GEORGIA

Bill Would Establish High-Risk Pool

In a recent news release, Dr. Merrill Matthews, director of the Council for Affordable Health Insurance (CAHI), applauded the state of Georgia "for considering legislation that would increase its citizens' access to affordable health insurance. The U.S. Congress made the high-risk pool funding available; now Georgia legislators must take action to help those who need health insurance coverage."

Last year Congress allocated $100 million to help states fund and establish high-risk pools. Thirty states already have these pools, which provide a safety net for uninsured people with a pre-existing condition who have been denied coverage, or whose medical condition has made the cost of coverage prohibitively high. CAHI encourages all states that haven't implemented high-risk pools to start them ... soon.

"As the nation continues to debate the best way to ensure access to affordable coverage, high-risk pools must be a part of the solution," Matthews says.

CAHI News Release
March 28, 2003

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IOWA

Lawmakers Raid Seniors Trust

In an effort to balance the state budget, Iowa lawmakers have reversed the Robin Hood syndrome by robbing a trust fund meant to keep the poor and elderly out of nursing homes.

The $392 million fund, known as the Senior Living Trust, pays for meal deliveries, visiting nurses, transportation, and other services that make it possible for many elderly people to live independently.

With tax revenues down, lawmakers have raided the trust for other uses. They took $48.5 million for 2002 Medicaid expenses and $36 million for such expenses in 2003. Governor Tom Vilsack (D) wants to take $65.6 million more by the end of the 2004 fiscal year.

The trust was started with $95.6 million from the federal Health Care Financing Administration in 2001. Tom Lenz, a regional official with the agency, now called the Centers for Medicare and Medicaid Services, said the money came with no strings constraining how the state could use it.

Mark Haverland, director of the Iowa Department of Elder Affairs, said the trust was intended to reduce the state's reliance on nursing homes and Medicaid by providing community services. Haverland, a former legislator, said the trust was an easy source of money. "The danger is when you spend this one-time revenue it goes away," he said, "and then next year you've got to fill an even bigger hole."

If the trust had been left intact, it could have drawn $10 million to $15 million each year in interest.

New York Times
March 29, 2003
Associated Press
March 28, 2003

MAINE

New Regs Single Out Drug Industry

Pharmaceutical industry representatives said several bills being considered by the state legislature "unfairly single out" the drug industry and would "serve little purpose" for consumers and physicians.

The bills would require drug companies to disclose the cost of their marketing and advertising practices. State legislators say action is needed to address increasing prescription drug prices by informing consumers the newer, heavily marketed drugs are not necessarily better than older or generic counterparts.

State Rep. Thomas Kane (D), co-chair of the House Health and Human Services Committee, said "The best, most effective strategy (to lower drug costs) is consumer knowledge, consumer empowerment, consumer choice."

Ann Robinson, counsel for the Pharmaceutical Research and Manufacturers of America (PhRMA), said a bill that would force drug makers to disclose how much they spend on consumer advertising would force companies to give up proprietary information and would not affect a physician's decision on whether to prescribe a certain drug.

The Portland Press Herald
March 25, 2003

Ready to Repeat Tennessee's Mistakes

The single-payer advocacy group Consumers for Affordable Health Care (CAHC) issued a set of five principles for lawmakers to consider in the health care debate. As a result, almost 100 health care reform bills are clogging up the state's legislative calendar. The guidelines describe a program strikingly similar to the failed Tennessee single-payer plan called TennCare.

Proposed legislation includes a measure supported by Governor John Baldacci (D), who pledged "Maine will be the first state in the nation" to implement a universal health care system for residents. Democrats control both the House and Senate.

Other bills include one introduced by State Rep. Stephen Bowen (R), which would foster broader support for and use of medical savings accounts (MSAs). State Rep. Chris O'Neil (D) said measures more "substantive" than Bowen's, such as the governor's single-payer bill, will be debated later in the session and should take precedence.

Bangor Daily News
March 17, 2003

MASSACHUSETTS

Thousands May Lose Medicaid Coverage

Health providers and business and religious leaders rallied March 27 for a 90-day moratorium on the budget cuts that would end coverage in MassHealth Basic for 43,000 beneficiaries. Providers have said the enrollment reduction, mandated by the legislature earlier this year to save the Medicaid program $32 million, will "ripple" through the health care system and affect many with private insurance through increased premiums and longer waits for emergency care.

As many as 6,500 beneficiaries may secure coverage through other Medicaid programs, and approximately 19,500 could receive care through community health centers and hospitals providing charity care. Nevertheless, advocates fear many people with chronic illnesses or substance abuse problems will die or "get so sick they require hospitalization." According to the *Boston Globe*, those without access to a safety net are expected to crowd emergency rooms or simply go without care.

The Civic Leaders Committee to Save MassHealth, among others, has proposed using the state's tobacco settlement funds to continue coverage through MassHealth Basic. Providers also are concerned the state's uncompensated care fund is expected to have a $165 million deficit this year.

State Health and Human Services Secretary Ronald Preston said he hopes to restore coverage as of July 1 by overhauling the program and its funding structure. However, Governor Mitt Romney (R) and lawmakers said the cuts are "unavoidable," and any move to prevent the cuts would have to originate in the legislature.

Boston Globe
March 28, 2003
Lexis/Nexis Research
March 31, 2003

NORTH CAROLINA

Prior Authorization Measure Considered

The House Ways and Means Committee is considering a bill requiring physicians to obtain prior authorization from state health officials before prescribing any brand-name drug to Medicaid beneficiaries.

The proposal, designed to reduce spending in the state's $6 billion per year Medicaid program, would tighten restrictions already in place. North Carolina currently requires physicians to receive prior approval from a pharmacy administrator before prescribing certain high-cost treatments, such as Botox, Celebrex, Vioxx, Zyban, and OxyContin.

In addition, the state Department of Health and Human Services limits its Medicaid reimbursements for some drugs. Barbara Brooks, administrator for the state Division of Medical Assistance, told the *Winston-Salem Journal* the current restrictions have saved the state more than $24 million, with Medicaid spending growing 11 percent in 2002 compared to 22 percent the previous year.

Winston-Salem Journal
March 26, 2003
Associated Press
March 27, 2003

Illinois Mulls Single-Payer Plan

Conrad F. Meier

The House passed H.B. 2268, the Health Care Justice Act, on April 1, and its potential $2.6 to $4 billion cost is no joke. Conservative lawmakers are saying the bill begins the implementation of a Canadian-style single-payer health care plan for Illinois.

Sponsored by State Rep. Willie Delgado (D-Chicago), the bill authorizes state government to implement a health care plan that provides access to a full range of preventative, acute, and long-term care services to all residents. The measure allows for the creation of a Bipartisan Health Care Reform Commission with members appointed by the Governor and legislative leaders. The commission would hold public hearings and report on February 1, 2005 and 2006.

A cost estimate prepared by the Department of Public Aid concludes, "There could be substantial and prohibitive costs when the final report is released. The bill does not contain any estimate of the future costs of comprehensive health care in Illinois.

"Last year," the Fiscal Note continues, "we estimated the cost of this proposal could be between $2.6 billion and $4 billion annually. It is doubtful the Department could finance a comprehensive health care program without federal participation, especially given the current state of State's fiscal condition."

A 25 to 40 percent income tax hike would be needed to finance the Democrats' health care proposal. The bill passed 60-45-11, achieving the bare majority needed for passage. It now goes to the State Senate for consideration.

HEALTH CARE NEWS

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Malpractice Reform Takes a Hit

continued from page 1

to increase or decrease the cap; no limit would be set for economic awards, which include medical costs and lost wages.

Palmisano said without a cap on medical malpractice awards, malpractice insurance premiums will continue to rise, and doctors will stop working because they cannot afford to pay those premiums.

"You can keep the present system, which has unlimited awards, and end up with citizens who no longer have a doctor to see," Palmisano said. "We think the present system is broken. We think the present system decreases quality. We think the present system denies access to care. If we don't get this passed, the meltdown is going to continue."

Support Gap

Senator Dianne Feinstein (D-California) said she will no longer support a bill capping jury awards for non-economic damages in medical malpractice suits at $500,000—twice the amount called for in HR 5—after the American Medical Association and California Medical Association (CMA) expressed opposition to the measure.

"There is no way I am going to introduce legislation that is going to be fought by my own doctors, who I am trying to help," she said. The bill was intended as a compromise to garner Democratic support.

The Senate measure also would allow awards of at least $2 million for malpractice cases resulting in disfigurement or physical disability and would not limit lawsuits against managed care plans or prescription drug companies.

According to research cited by Palmisano, a $500,000 cap would not reduce malpractice insurance rates. "[W]e do not want to give support if it turns out to be something that will not do any good," he said.

Although the compromise measure would not override state laws already in place, Jack Lewin, chief executive of the CMA, said it "puts pressure on California to change a very good piece of public policy." He added Feinstein is "right in holding back right now." California law caps non-economic damages at $250,000.

Feinstein's withdrawal of support could be a direct hit on both the Bush administration and Republican leaders who repeatedly say they saw an opportunity to bring about reform this year.

Senate Majority Leader Bill Frist (R-Tennessee) said he plans to continue negotiations with Feinstein to reach an agreement on a bill physicians' groups would support. "I told the AMA we've got to develop a bipartisan bill, a bill acceptable to senators on both sides of the aisle, and they should make a decision as to what to support."

Stepping Up

Senate Judiciary Committee Chairman Orrin Hatch (R-Utah) and Judd Gregg (R-New Hampshire), chairman of the Senate Health, Education, Labor and Pensions Committee, blamed rising jury verdicts for increased malpractice insurance premiums. Hatch dismissed claims from consumer and trial lawyer groups that recent spikes in malpractice premiums are more the result of lower investment returns in the weak economy.

"The real fault," said Hatch, "lies in the fact that we haven't handled this problem very well."

Hatch and Gregg reported their committees would hold a joint hearing on the issue, although they did not say when. Hatch also said the Senate would likely take the House bill as a starting point.

Damage caps have not proved popular in the Senate, and Hatch indicated he is willing to compromise on this polarizing issue. "The problem is if you set a cap on the amount juries can award," Hatch explained, "jurors will go to the [cap] and it will become a floor." He added, "Jurors don't realize they pay the cost of high verdicts when insurance companies raise premiums for doctors who then stop practicing."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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A MONTHLY REVIEW OF HEALTH POLICY MATTERS

RECENT ARTICLES & STUDIES

The Uninsured:
A Study of Health Plan Initiatives and the Lessons Learned
National Institute for Health Care Management
March 2003

This study conducted by the National Institute for Health Care Management (NIHCM) examines 13 private-sector initiatives to analyze how private health plans have tried to cover the uninsured in recent years and to identify the lessons learned from these initiatives.

Successful health plans target small businesses and non-poor people who do not qualify for public programs. Successful plans are "characterized by aggressive marketing to the target population, affordable coverage choices, and flexible product design." The results of the study demonstrate "the success of public/private partnerships in launching programs aimed at expanding health insurance coverage."

Full text (pdf): **www.nihcm.org/UninsuredFull.pdf**

Increased Drug R&D through Increased Promotion
John R. Graham
Fraser Forum, March 2003

Canada and the European Union should follow the example set by the U.S. and significantly deregulate direct-to-consumer (DTC) advertising, says the Fraser Institute's John Graham. Graham points to data from the U.S. that "shows a very positive relationship between spending on promotion and on R&D." Graham says, "If it [DTC advertising] were prevented from communicating the value of its products to doctors and patients, sales would be reduced, and the incentive to conduct R&D would be much less. ... More DTC advertising leads to better treatment of patients today and more R&D invested in finding new medicines for patients tomorrow."

Full text (pdf): **www.fraserinstitute.ca/**

The 2003 Medicare Trustees' Report
Centers for Medicare and Medicaid Services
March 17, 2003

The financial stability of Medicare has declined from last year due primarily to lower-than-expected revenues and higher-than-expected hospital spending in 2002. The Hospital Insurance Trust Fund (HI) will face insolvency four years earlier than was projected last year, now expected to be exhausted in 2026. Expenditures will now surpass revenues in the HI program in 2013.

"Without changes in the Medicare program, closing the projected HI gap between revenues and expenditures would require that benefits be reduced by 42 percent, or income from the payroll tax would need to be increased by 71 percent," the report said.

Full text: **www.cms.hhs.gov/publications/trusteesreport**

Demonizing Those Who Cure Us
Doug Bandow
Washington Times, March 15, 2003

Doug Bandow of the Cato Institute argues, "Americans can't get something for nothing: Canadian-style prices in the United States would mean Canadian-style access to pharmaceuticals in the United States."

In Canada, he says, "Pharmaceutical controls have sharply cut access to needed drugs. Of 400 drugs considered for reimbursement by the Canadian province of Ottawa between 1994 and 1998, only 24 were added." This denial of new drugs has "horrible consequences for the sick." He warns the U.S. against going down the path of price controls. "Canada manages by free riding off of the United States. Alas, there is no one off of whom Americans can free ride."

Full text: **www.townhall.com/columnists/dougbandow/db20030318.shtml**

Grace-Marie Turner

The former director of the Congressional Budget Office, Dan Crippen, advised the Senate Aging Committee to understand a problem before spending hundreds of billions of dollars to fix it. What a novel idea!

The man who produced cost estimates for Congress for four years has suggested to Congress it might be wise to start by counting who most needs help with health insurance and prescription drugs before enacting hugely expensive new programs.

For example, Crippen said less than half of the 41 million uninsured are without coverage for 12 months or more. The other 20 million are between jobs, between spousal coverage, and between public programs. The average period without health insurance is seven months, and 40 percent are uninsured for fewer than four months.

We've said for years that many people are uninsured precisely because we so closely tie health insurance to the workplace in this country, forcing people to lose their health insurance when they change or lose their jobs and discriminating through the tax code against those who don't have the option of job-based coverage.

The solution is not to give everyone the "stability" of government-sponsored health insurance—heaven forbid—but to fix the system that kicks people off the insurance rolls so arbitrarily!

"Until the nature of the problem is clear, the solutions we devise may be ineffective and unnecessarily costly," Crippen said. This could suggest targeting new programs to people who are chronically uninsured and have low incomes.

Crippen made a similar point in talking about a Medicare drug benefit. He noted it's important for legislators to recognize that three-fourths of seniors already have coverage. If

"Congress should take a careful look at how it plans to spend taxpayer money to make sure we get the results we expect."

the government has limited money to spend, even the *Washington Post* recommends a targeted, low-income benefit.

Health insurance and drug coverage are important for those who lack it. That's why Congress should take a careful look at how it plans to spend taxpayer money to make sure we get the results we expect.

The conversation over health reform continues, even as Washington is consumed by plans for war. Please pray for our soldiers.

The Medicare Challenge: It's Not Just about Prescription Drugs
Douglas Holtz-Eakin
Congressional Budget Office Testimony
March 20, 2003

"Any approach to Medicare should incorporate two features: A recognition of the larger economic and budgetary tradeoffs, and consideration of the program structure that would best support Medicare's overall objective of providing financing for high-quality medical care for the elderly and disabled," said Doug Holtz-Eakin, director of the Congressional Budget Office, in recent testimony before the Senate Special Committee on Aging.

He discusses the value of improved decision-making by beneficiaries, the efficient use of Medicare dollars, and demographic trends in the Medicare population. Without change, Holtz-Eakin warns, Medicare "will cause a substantial deterioration of the fiscal position of the U.S. government."

As an example, he cites the Medicare Trustees' report estimate that Medicare will consume 9.2 percent of GDP by 2075. "If the Medicare program's costs today accounted for 9.2 percent of GDP, they would equal half of what is now spent under the entire federal budget."

Full text: **www.cbo.gov/showdoc.cfm?index=4108&sequence=0**

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, **http://www.galen.org**. *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of Health Care News.*

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MYTURN

Advocacy Groups Inflate Number of Uninsured

Three of the most powerful liberal advocacy groups in the country spearheaded an unprecedented $8 million campaign to persuade Americans to take yet another step down the road to a single-payer health care system.

The Robert Wood Johnson Foundation, Families USA, and Commonwealth Fund were the driving forces behind "Cover the Uninsured Week" (March 10-16)—an intense effort to turn Medicare into something resembling the antiquated and crumbling health care systems of Canada and England.

Fiction into Fact

The number of uninsured in America is, without doubt, a major social issue meriting our concern and policymaking efforts. But by exaggerating and misrepresenting the reasons Americans are uninsured, the Cover the Uninsured propaganda blitz seems less aimed at helping the truly needy than it is designed to advance the threadbare statist agenda of price controls, insurance mandates, and expanding Medicare.

A 53-page study by Families USA claims an eye-popping 74.7 million people under the age of 65 in the United States went uninsured "for all or part of a two-year period from 2001 to 2002." Ron Pollack, head of Families USA, uses this figure to call for "real and meaningful action to expand health coverage."

But Pollack's estimate of the number of uninsured is meaningless. Anyone who was uninsured even briefly during the two-year period gets added to the "uninsured" population. It's like calling "unemployed" anyone who took a week or month off between jobs, or tagging as "homeless" anyone who moved from one house to another. Remove from Pollack's figure the 26.2 million Americans who were uninsured for only one to five months, and you reach a more plausible uninsured figure of 48.5 million.

The more commonly cited estimate of the number of people without insurance for some length of time in a single year is 41 million. Yet even this number is suspect, because emerging studies indicate about half those people were uninsured for a brief period of only three months or so, with the balance being chronically uninsured because of medical conditions, economic conditions, or voluntary choice. (Yes, some people, especially those who are young and healthy, make a perfectly rational decision to self-insure.) Another 9 million of the uninsured are legal and illegal immigrants.

Who Are the Uninsured?

A current report by the Blue Cross Blue Shield Association finds more than 14 million of the 41 million uninsured are eligible for Medicaid or the State Children's Health Insurance Plan (SCHIP), but have not enrolled. More than 15 million have incomes of $50,000 or more and would purchase insurance if they thought it valuable, but they choose not to. The fastest-growing population of uninsured people earns an income of $75,000 or more.

According to the Blue Cross study, 5.7 million are short-term insured, such as recent college graduates or people between jobs. The report also indicates 5.2 million uninsured are in three states with a high number of illegal immigrants: California, Texas, and New York.

Do these numbers suggest the need for expanding government-run health care to middle-income and upper-income families, imposing new regulations on health insurers, or violating the patent protections of drug manufacturers ... all reforms advocated by the groups responsible for the Cover the Uninsured campaign? I think not.

The mandates they propose would waste billions of dollars solving the uninsured problem, and yet would likely miss the population needing the most help. Just as important, new mandates would further undermine a private health insurance marketplace that offers the best hope of solving the real problems afflicting the nation's health care finance and delivery system.

Insurance and Health

In addition to using overstated statistics to advance their agenda, promoters of Cover the Uninsured Week would have us also believe not having health insurance is a cause of health problems.

While more research is needed to understand the health insurance-health quality dynamic, some studies have shown the uninsured do not suffer greater health problems than the insured.

Dave Kopel, research director at the Independence Institute, recently reported the National Bureau of Economic Research (NBER) found "the lack of health insurance among the self-employed does not affect their health. For virtually every subjective and objective measure of their health status, the self-employed and wage earners are statistically indistinguishable from each other."

There are four viable solutions to the uninsured problem: Expanding high-risk health insurance pools for the medically uninsurable in every state; repealing insurance coverage mandates that encourage people to go without insurance until they become ill; making medical savings accounts permanent and more flexible; and passing individual and refundable tax credits for every American citizen—over and under the age of 65, currently insured, uninsured, employed, self-employed, and unemployed. Leave no one out.

The powers behind Cover the Uninsured Week oppose each of those reforms, desperately promoting their own agenda by distorting and ignoring the facts.

Conrad F. Meier is senior fellow in health policy and managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

The Blue Cross Blue Shield Association fact book, *The Uninsured in America*, is available from the BCBS Web site at **http://bcbshealthissues.com/whoareuninsured/**.

The National Bureau of Economic Research's September 2001 working paper, "Insurance and the Utilization of Medical Services among the Self-Employed," is available for $5.00 from the NBER Web site at **http://www.nber.org/papers/w8490**.

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❑ Other _____

❑ My check in the amount of $_____ is enclosed.
❑ Charge $ _____ to my ❑ Visa ❑ MC ❑ Am Ex

Account Number _____
Expiration Date _____
Signature _____

Name _____ Home Phone _____
Title•Company _____ Work Phone _____
Address _____
City•State•Zip _____

❑ *Please send me additional information about The Heartland Institute.* ❑ *Please send me information about advertising in HCN.*

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